





EXHIBIT “2”

P.O. Box 830847
Miami FL 33283-0847

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, SET OUT BELOW		
CHECK CARD USING FOR PAYMENT		
		
		
CARD NUMBER		
SIGNATURE		EXP. DATE
STATEMENT DATE 11/25/24	PAY THIS AMOUNT \$ 643.20	ACCT. # 17173825-1
SHOW AMOUNT PAID HERE		\$

KEN55C 5145943 655130605

Heriberto Valiente
4214 SW 164TH PATH
MIAMI FL 33185-5290



Kendall Credit
and Business Service, Inc.
P.O. Box 404665
Atlanta, GA 30384-4665



0001717382510000064320201007

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

**** Please include your account number on all forms of payment ****

Si necesita una interpretacion de esta carta, por favor comuniquese con nuestra oficina.

PLEASE CALL Darlene Gingras AT (786) 594-6688 EXT. 46666

Creditor: Baptist Hospital
Debtor: Valiente, Heriberto
Account No.: 17173825-1
Service Date: 07/11/24
Amount Due: \$643.20

You have not responded to our first collection notice, therefore we will now pursue full collection efforts. To avoid further collection efforts, send your payment in full to our office.

If you are unable to pay this amount in full now, please call us today and make an acceptable arrangement. Do not delay this important matter which requires your attention.

**** Please include your account number on all forms of payment ****

***** To pay online go to: <https://billpay.baptisthealth.net> *****

Federal law requires us to inform you that this is an attempt to collect a debt and any information obtained will be used for that purpose.

This communication is from a debt collector.

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

Herberto Valiente

If you have new health insurance or a new address, please enter the information below.

17173825-1

NEW ADDRESS		CITY	STATE	ZIP CODE
NEW PHONE#		NEW EMAIL ADDRESS		
POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT		POLICY ID #	GROUP #	
EFFECTIVE DATE	BIRTH DATE OF INSURED	HMO/PPO/OTHER	INSURANCE PHONE #	
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)				
INSURANCE COMPANY NAME		INSURANCE ADDRESS		
EMPLOYER		EMPLOYER ADDRESS		